Adult Services and Wellbeing
Calderdale Metropolitan Borough Council

Standard Operating Procedure (SOP): Learning Disability and Neurodivergent Team.

Contents

Procedure Version Control

Procedure Name	**Standard Operating Procedure: Learning Disability & Neurodivergent Team.**		
Document Description	This Standard Operating Procedure sets out the Learning Disability and Neurodivergent Team's aims, objectives, underlying principles together with consistent ways of working.		
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Version Number	**Date**	**Amendments**
1.0	August 2024	New Document
2.0	December 2024	Amendments Made to Waiting Well process, and that initial Safeguarding Concerns for Learning Disabled or Neurodiverse Adults are now managed through the Safeguarding Adult Team.
3.0	December 2024	Track Changes from Anne Flanagan, changes to duty process.
4.0	January 2025	Changes from Anne Flanagan accepted, updates made to Duty Process.

Learning Disability and Neurodivergent Team Standard Operating Procedure

Service Overview

The Calderdale Learning Disability and Neurodivergent Team supports people over the age of 18 who have a confirmed diagnosis and require personalised support to enhance their daily living and achieve their outcomes. The team also support young people in preparing for adulthood prior to them leaving school and support with the pathway of moving to adult services.

The team strives to enable people and their informal carers to lead fulfilling, safe and independent lives by providing information, advice and guidance and offering practical, personalised support with everyday activities.

The team works in collaboration with many other agencies, such as our local commissioned providers, housing, health services, youth services, police, and voluntary and community and faith organisations.

Service Main Aims

Promote Autonomy and Resilience:

- Support people to achieve their outcomes by providing strengths- based guidance and support and personalised support planning..
- Encourage self-management and resilience through empowerment, confidence and skills building.
- Work alongside people with lived experience to improve practice and to ensure support and guidance are outcome focused with as much choice and control as possible.

Enhance Quality of Life:

- Improve people's overall quality of life by addressing social, emotional, and practical needs.
- Support access to education, employment, and leisure activities.

Ensure Holistic and Person-Centred Care:

- Provide care that is tailored to the unique needs and preferences of the person.
- Involve people in planning and decision-making processes to ensure care and support is relevant and effective to them.

Promote Social Inclusion and Reduce Stigma:

- Encourage social inclusion by supporting community engagement and reducing isolation.
- Work to combat stigma and discrimination, valuing people's unique strengths as well as their needs.
- Develop culturally appropriate services, ensuring services are open, welcoming, and accessible for all, whatever the person's cultural identity or heritage.

Support Independence and Autonomy:

- Help people achieve greater independence by supporting daily living activities and life skills development.
- Facilitate access to housing, employment and other essential services that promote autonomy.
- Provide advocacy support for people to ensure their voice is heard.

Crisis Intervention and Support:

- Provide timely and effective crisis intervention s to prevent escalation and ensure safety.
- Offer ongoing support to people and their families during and after a crisis.
- Support people to access other agencies such as physical and mental health resources by making appropriate referrals and support.

Promote Family and Carer Support:

- Recognise and value the role of families and carers in supporting people with personalised planning.
- Provide education, resources, and support to families and carers to help them in their roles.

Advocate for Peoples Rights:

- Advocate for the rights and needs of people with a learning disability and/or neurodiversity within the broader community and policy framework.
- Ensure people are treated with dignity and respect in all interactions.
- Ensure reasonable adjustments are made, communication tools and appropriate equipment are utilised.

Promote Prevention and Early Intervention:

- Focus on early identification and intervention to alleviate undue stress and work collaboratively with other professionals to plan, develop and deliver effective services.
- Implement innovative, creative and evidence informed solutions to address risk and promote well-being.

Service Objectives

- **Assessment and Eligibility:** Conduct thorough assessments to determine the persons' needs and eligibility for care services.

- **Care Planning and Review:** Develop personalised care plans that outline the support and services required to meet the persons assessed needs.

- **Access to Services**: Ensure that people have timely access to a range of appropriate care services which might include home care, supported living, residential care, day services, and respite care.

- **Collaboration with Key Partner Agencies:** Promote collaborative and partnership working to ensure coordination of health and social care services that provide seamless support to people.

- **Empowerment and Choice:** Empower people to make informed choices about their care and support options.

- **Prevention and Early Intervention:** Focus on preventative measures and early intervention to increase autonomy and choice.

- **Workforce Development:** Invest in the recruitment, training, and retention of a skilled and compassionate social care workforce.

- **Community Involvement:** Encourage community engagement and the development of support networks to enhance the social inclusion of care recipients.

- **Quality Assurance:** Monitor and evaluate the quality-of-care services to ensure they meet high standards and are continuously improved.

- **Safeguarding:** Implement robust safeguarding policies and procedures to protect adults at risk from harm.

- **System Leadership:** Lead on multi-agency care planning for people with complex and high-risk support needs.

- **Cost-Effectiveness:** Ensure that resources are used efficiently to provide high-quality care while managing public funds responsibly.

- **Section 117:** Ensure people who are entitled to Section 117 (Mental Health Act 1989, as amended, 2007) aftercare services receive a holistic assessment or review of their mental health care alongside their ongoing support needs in collaboration with ICB colleagues.

- **Enablement:** To empower people to achieve greater independence, enhance their quality of life, and actively participate in their communities by providing personalised support and resources.

Service Outcomes

- More people living their life in the best possible way for them, so that they are healthy, happy and have a network of support, friends, and live in a place they call home.
- A reduction in the number of people admitted to hospital, residential or nursing care and more people using personalised support to meet their needs in the community.
- An increase in the number of people living independently, in paid work and who are in charge of their own care to meet their longer-term needs.
- A reduction in the number of people solely supported by statutory services and an increase in the number of people being supported within their communities.
- Ensuring people can live a life free from abuse and or neglect.
- Fulfil our commitment to promote equality of opportunity and working towards embedding equality, diversity and human rights principles as part of strategic decision-making.
- Facilitate timely and effective assessments with multi-disciplinary teams.
- Promote people's human rights with a focus on strengths-based practice including promoting positive risk enablement.
- Carers and families are identified and recognised and have access to information and practical and emotional support to help them achieve the outcomes which matter most to them.

Values and Principles of the Service

- The Service aims to provide high quality services, which are economic, efficient, and effective.
- To ensure equity of access and equality of opportunity and outcomes.
- To ensure that people are safeguarded in line with their wishes whilst promoting a making safeguarding personal approach.
- To work effectively in partnership with other services, agencies, and communities.
- To be open, transparent, and accountable.
- To be a learning organisation/service that seeks continuously to improve through innovation and flexibility

- To deliver on our Adult Social Care Wellbeing Principles

Eligibility Criteria and Contacting the Service

The team accept self-referrals, referrals from another professional or support worker, the persons carer, representative or family member or friend. Referrals can be made via Gateway to Care or Link into Calderdale (LINC)

- Phone: 01422 393000
- Email: gatewaytocare@calderdale.gov.uk
- Website: Calderdale's Community Information Directory | CalderConnect - Advice for Adults (calderdalechildcare.org.uk)

Service Delivery

The Learning Disability and Neurodiverse Team is operational Monday to Friday 9am to 5pm.

Outside of these hours the Calderdale Emergency Duty Team can be contacted on

01422 288000

Service Process and Procedures

Initial Contact

All Referrals are received in one of two ways:

1. Via Gateway to Care
2. Via Link into Calderdale (LinC)

Referrals that are submitted to Gateway to Care are received via a central email inbox. This is screened by the Prevention and Early Help service and sent on to the most appropriate team for ongoing support.

The person referred will receive contact via their preferred method; telephone call, text, email, acknowledging the referral and advise of timescales.

People will be encouraged to contact the duty email inbox should their circumstances change. People referred via Gateway to Care will have been notified at the point of the referral being raised with the team and that there may be a waiting time depending on the assessed urgency of the need.

Duty Process

Duty work is defined as being able to provide an immediate response to urgent issues that arise. The role is essential for ensuring that support is available when unplanned or critical situations occur that arise from a social care need or where a social care intervention is required.

People awaiting an allocated worker can contact duty if their needs change or the situation becomes more urgent. If a person already has an allocated worker that worker will be the first point of contact.

The team have a management email inbox which is monitored and managed daily by the Team Manager and the Team & Practice Leads. All referrals to the team are raised on to the Client Information System (CIS). People who have an existing referral or who are already allocated within the team, are provided with the team duty email address and are notified to contact the team should there be a change in circumstance or a need for contact outside of agreed arrangements. For people not known to the team Gateway to Care is the first point of contact.

The Team Manager / Team/Practice Leads will identify and delegate appropriate duty tasks to individual members of the team with clear timescales for a response and outcome. Staff members are required to ensure they record their interventions on CIS, identifying the outcomes and any additional actions required. Staff are required to feedback to the management email inbox to confirm work has been completed and the outcome of the duty intervention.

The staff team are on duty on a rotational basis for fair delegation of work. An alternate manager is identified to provide oversight and support to the team also. In the event of unplanned absence, a manager will send out an email to the full team requesting for a worker to volunteer to undertake and action duty tasks. Operations Manager direction will be sought in the event that there is capacity and response challenge to duty work.

Waiting Safe and Well Process

Due to demand, it is not always possible to respond immediately and sometimes people are waiting for assessment or review. It is particularly important that that people waiting for assessment for adult social care are appropriately prioritised and that they receive regular updates, and resources that support their well-being while they wait, in order to reduce risks associated with unmet needs.

On receipt of the referral, the ***Screening Tool for Referral Waiting Lists*** should be used to prioritise referrals – this applies to assessments, re-assessments and reviews. The prioritisation tool will be used to establish the level of need and risk, and to ensure that people are allocated in an equitable manner. People will be recorded as high, medium, or low priority for allocation based on their individual circumstances.

In line with section 6.26 of the Care Act Statutory Guidance, if an immediate response through service provision is required to meet a person's urgent needs to ensure their safety prior to an assessment being undertaken - this should be put in place on an interim basis.

The outcome of the prioritisation should be documented on the Team Referral Spreadsheet which is held by the Team Manager and used in conjunction with the electronic recording system referral lists. The spreadsheet is date ascending for referral submission and color coded for priority rating:

Red	**High Priority**
Yellow	**Medium Priority**
Green	**Low Priority**

As part of the 'waiting safe and well' process, all people awaiting a new assessment will be contacted to determine if their situation has changed and, if needed, relevant safety actions implemented; this may include fast-tracking the persons assessment. This process should be undertaken in line with the ***Waiting Well Framework.***

All people who are waiting for more than two weeks will be sent a standard waiting well letter to confirm that they are still on our waiting list. The letter will provide service contact details, information on how to inform us if their situation changes and will provide signposting to other information and support options (such as CalderConnect, Care Charge calculator). It will also provide details of our Better Lives Drop in Hubs.

Whilst people continue to wait for allocation, we will contact them on a regular basis to review their circumstances and any changes in needs, which may affect the level of risk and their prioritisation. The frequency of contact is tailored and proportionate to their level of priority.

The contact may be through a follow up Waiting Well letter, by telephone or by text.

Where a change in circumstances, need or risk becomes apparent, then the level of priority will be re-assessed using the prioritisation tool.

If a significant risk is identified, this will be escalated to the team manager and appropriate action taken. This could result, for example, in a telephone assessment and interim support arrangements or urgent allocation.

Should it become apparent that the person has resolved their own needs, then the referral will be closed.

Contact will be recorded in the persons case notes on CIS and the Team Manager / Team Leader will update the spreadsheet accordingly during the weekly referral review.

Assessment and Eligibility Process

The Care Act 2014 is used to inform what information should be considered to support determination of eligibility. Assessments are completed through information collation; strengths-based conversations with the person and relevant representatives / professionals, observations and review of written records and reports. Consideration is given at the start of this process to the persons capacity to consent to assessment and organising a suitable representative or advocate to support if the person lacks capacity to consent. The priority is that assessments are robust, clear and reflect a person's strengths, goals and outcomes they wish to achieve.

This information is then recorded into a needs assessment, referred to as the Living Well document, which outlines the persons care and support needs, wellbeing outcomes and determination of eligibility (s13 Care Act 2014). People will receive a copy of this assessment and are encouraged to review and provide comment/feedback. For people lacking mental capacity to consent, assessments are shared with a suitable representative and/or advocate.

Once a determination of eligibility has been identified, practitioners will support people to understand how the determination has been reached and appropriate forms of support to meet eligible unmet care and support needs. This will be achieved either via a telephone call or in person. The practitioner will record this conversation in the persons case notes on CIS.

Financial Assessment

Calderdale Adult Services and Wellbeing have a financial pathway and policy which all adult social care teams follow.

At the point of contact with adult social care, people will be verbally notified when being referred for an assessment of need under the Care Act 2014 or changes to existing services, that any eligible needs for which a commissioned service may be offered will be subject to financial assessment and a possible care contribution. People will be signposted to the adult social care platform on the council website which has a basic calculator, enabling people to get a rough approximation of likelihood and amount they may have to contribute towards care.

At the start of the assessment process people will again be verbally informed of this information and provided with hard copies of the council's care charging leaflets. It will be established as part of the assessment how a person manages their finances, if there is an appointee or a legal representative, such as Lasting Power of Attorney (LPOA) for Finance and Property or Court Appointed Deputy. Details for any person formally supporting or managing with a person's finances will be taken and they will be consulted as part of the assessment process. If a person has no such individual but there are concerns over the persons capacity to manage their finances, a mental capacity assessment should proceed considering how the person may be supported and to enable financial wellbeing. This may include signposting the person to

community resources, offering practical advice and guidance, or seeking to identify a suitable person in a suitable role to formally manage finances.

Once the assessment is completed and if eligible needs are identified for which a chargeable service is likely to be offered,, social care staff can support people with filling the Financial Information Forms (FIF) in and returning these with attached documents to the care charging team. Alternately FIF forms can be provided in hard copy in person, via post or electronically via email to an appointee or legal representative to complete and return to the care charging team.

Social care staff include as part of this pathway, explicit reference and stipulation to any Disability Related Expenditure (DRE) which may affect care charging determination. Social care staff will ensure people's explicit consent to proceed with organising chargeable services is sought. People have the right to await a care charging decision before committing to accepting or declining services.

If a person is deemed to lack mental capacity to manage their finances without a suitable person identified, a best interest assessment will be carried out and a decision made whether it is in the persons best interests or not to proceed with organising a chargeable service. The worker will notify the care charging team of this information and identify the steps being taken to seek a suitable person to manage the persons finances and a likely timescale for resolution. This will ensure the person is not disadvantaged from receiving appropriate care and support and that care charging teams can place any potential charges on hold until suitable arrangements can be made to organise payment. Calderdale MCA and BID documents should be clearly recorded, associated to the persons electronic file, and referenced within case notes on CIS.

If chargeable services are organised social care staff will remain actively involved and allocated until financial assessment, care charge and payments have been set up. Specific reference to the persons journey through the financial pathway should documented within electronic recording systems and at the point of closure. Team Managers / Team Leaders will quality assure during closure checks to ensure due diligence has been paid to follow the financial pathway.

Care and Support Planning

As part of the assessment of need process, peoples' strengths, interest, and goals for the future will be explored considering wellbeing outcomes and if/how these outcomes are met. Workers will support people to recognise their strengths and to understand what would meaningfully enable them to achieve those outcomes, providing information and advice so they can make choices about self-directing support.

If a person is identified as having eligible needs where these are or will be met by nonchargeable services, local process indicates that a formal care and support plan will not be created. Alternately the living well document will clearly demonstrate how

those needs will be met, citing the specific resource, agency or support that the person can access to meet their needs.

For eligible unmet needs where a chargeable service is identified as suitable, a formal support plan will be created. This will be co-produced with the person, identifying whether needs are met or unmet, support currently in place and what additional support will be organised to achieve outcomes. This includes what chargeable service is to be organised, detailing the agreed hours and cost of this service. Social care staff will draft care and support plans based on the conversations and contact with people, providing draft copies to people and/or representatives for comment and review to ensure both the person and social care are contented these are accurate and reflective of the person. For people who are unable or unwilling to participate in support planning, this should be clearly documented within electronic case recordings detailing what the worker has done to promote participation and relevant representatives or advocate they have involved. Once the support plan is agreed this will be formalised, local process followed in regard to organising chargeable services, and signed copies provided to the person and associated to their electronic record.

Care and Support Services

Care and support services refers to all types of support to enable people to achieve their wellbeing outcomes. These can include but are not limited to; community resources, third sector support, primary and secondary care, universal services such as housing, chargeable commissioned services. Chargeable services include care within the community, respite care, supported living, residential and nursing care.

Workers will ensure that as part of the assessment of need process, they are considering the strengths and goals the person has and all available type of support to meet those needs and goals. Support is not limited to one type of service, and it may be that combination of services are utilised to enable a person to meet their outcomes, referencing to Calderdale 8 P's; Item 6 App 6.pdf

Workers will identify suitable options to present to the person, enabling them to make choices about how they would like to meet their needs and appropriate support to achieve that. In respect of chargeable services, workers will clearly explain and document the amount of support they would suggest is awarded. Financial pathways should be referred to, ensuring people are aware of the choice to accept or decline services, including organising their own services if they prefer and have the financial means to do so. For those people who are eligible for funding under a specific framework, such as Section 117 after care, people will be notified as to how their care will be funded and review mechanisms for this.

People will be informed that social care staff will need to follow internal procedure regarding seeking budgetary approval for chargeable services. Workers will ensure people are informed that chargeable support is awarded on a need led basis and should there be a difference between assessed need and preferred levels of support,

people can choose to organise the difference privately. Options for support delivery will then be explained to the person, dependent on the type of chargeable services, as to whether they would like to organise their own support via a direct payment, or if they would like for the council to organise this through a managed service or contract.

Workers will support people and/or representatives to understand the mechanism for how support is delivered may differ and considering which may be preferable for them. Once a person has indicated their preference for how support is delivered, the worker will explain the next steps and likely timescales for support being organised.

Review of Care and Support Plan

People will have their care and support plans reviewed initially at around 6weeks, post support commencing. This a standard adult service process, ensuring that support is working well to meaningfully achieve wellbeing outcomes or if there are any remedial issues presented these can be addressed and resolved at the earliest point possible. Reviews can be completed either in person, via telephone or via email dependent on the complexity of the circumstance and any communications requirements or adjustments the person may have. The outcome of the review will be agreed with the person and discussions will take place to ensure there is a clear understanding about any further actions required from adult social care. If support is working well and does not need to change or reduce - reviews will then defer to annual, occurring 12 months post the last review completion.
Initial reviews are formally recorded within reviewing screens on electronic recording systems. Workers will be required to input the next review date due and raise a referral to the pending review electronic system, to ensure this is tracked and the next annual review allocated within timescale.

Annual reviews will be allocated to a social care worker to complete. This will involve coordinating a face-to-face meeting with the person and provider / or Direct Payment (DP) holder to review identified outcomes, support in place and if this is working effectively to meet needs. For people who receive support in a 24-hour care setting, providers will be sent a review report to complete ahead of the meeting to support a thorough review and quality assurance check. Reviews will be recorded and reflected on electronic recording systems.

Case Recording

Case recording is an essential part of daily social work practice. It includes:

- Recording the views of the adult and their carers.
- Writing down the work that has been undertaken.
- Life history, assessments, and analysis.
- Recording all contact made with person, carer or other professionals.
- Documenting the progress adults make towards their desired outcomes.

Case recording also provides an evidence trail of the work undertaken with an adult, and their carer and is a vital tool to enable staff to reflect on their ongoing work with adults / carers and plan future work. Records should be used as part of supervision, in conjunction with their supervisors / managers.

Staff should always remember that in the event of a safeguarding enquiry or other investigation, case records will be used and scrutinised. Staff will be held accountable for all entries they make and should be mindful of this when documenting their actions and professional judgements.

Staff should also remember that records may be shared with the adult, and this should be reflected in the language used and the way judgements are recorded.

Case records should:

- be based on a general principle of openness and accuracy:
- be drawn up in partnership with the adult.
- record the views of the adult, in their own words where appropriate, including whether they have given permission to share information.
- be an accurate and up to date record of work, which is regularly reviewed and summarised.
- include a record of decisions taken and reasons for them.
- include a chronology of significant events.
- be evidence based and ethical.
- separate fact from opinion.
- incorporate assessment, including a risk assessment where appropriate.
- include an up-to-date care and support plan.
- record race / ethnicity, gender, religion, language and disability.
- be used by the supervisor / line manager as part of overall measurement of staff performance.
- include management sign off where appropriate.
- be kept securely and shared in accordance with data protection principles (see Data and Protection Act 2018)

In addition to ensuring the principles above underpin case recording, other areas to consider include:

- the adult's voice should not be 'missing' from the case record: whilst actions taken in relation to them are documented, their wishes, feelings, views and understanding of their situation should be clearly recorded. There may be a tendency to focus on the views of a carer who is able to be more vocal, rather than the adult who may have more difficulty in expressing themselves.

- the size of the record may make it difficult to manage: records should be focused, and important information highlighted and regular summaries /transfer summaries included to make it easier to find for others reading the record, emails should be associated to file and a brief summary included in case notes.

- a completed assessment should be on file: information must be analysed, and a plan created for the assessment to be complete. An assessment is not just about collating information.

- the record must be written for sharing: making it easy for the adult to read and understand. Language should be plain, clear, and respectful, keeping social work terms and abbreviations / acronyms to a minimum. Records should be shared regularly with the adult to encourage them to contribute to the record.

- the record should be used as a tool for analysis: it should not simply record what is happening, but also to analyse and hypothesise why particular situations and events are occurring. The use of genograms, chronologies and assessment records can help organise and analyse information.

Information Sharing

Information sharing is a critical component of providing effective and coordinated care. Adhering to these procedures ensure that information is shared appropriately, respecting confidentiality and legal requirements while promoting the well-being of people receiving care and support. Consent to share information should be gained, if the person does not have mental capacity, then a Mental Capacity Assessment and Best Interests report should be completed and associated to file.

Purpose and Necessity

- **Define the Purpose:** Clearly identify the reason for sharing information, ensuring it is relevant and necessary for the person's care and support.
- **Assess Necessity:** Determine if sharing information is essential to provide care, protect people, or comply with legal obligations.

Consent and Involvement

- **Obtain Consent:** Seek explicit consent from the person to share their information, ensuring they understand what will be shared, with whom, and why.
- **Informed Decisions:** Provide the person with sufficient information to make informed decisions about their consent.
- **Document Consent:** Record the consent given, noting any conditions or preferences expressed by the person.
- **Lack of Consent:** In situations where consent cannot be obtained, information may still be shared if it is necessary to protect the person or others from harm (e.g., safeguarding concerns). Where the person lacks the Mental Capacity to consent a Best Interest Decision will be made regarding involvement and process.

Confidentiality and Data Protection

- **Respect Confidentiality:** Ensure that information shared is kept confidential and shared only with those who have a legitimate need to know.
- **Data Protection Laws:** Comply with data protection laws, such as the General Data Protection Regulation (GDPR), which governs how personal information should be handled and shared.

Information Accuracy and Relevance

- **Ensure Accuracy:** Verify that the information to be shared is accurate, up-to-date, and relevant to the intended purpose.
- **Limit Sharing:** Share only the information necessary to achieve the intended purpose, avoiding the disclosure of excessive or irrelevant details.

Risk Assessment and Safety Planning Process and Procedures

As part of worker's intervention with any person accessing the team, risk consideration and assessment will form part of this workflow. It's important that risk should be identified as specific to a factor or circumstance to reasonably consider the type, likelihood, severity, and if/what impact this may have for the person or other persons. This will indicate which agency or person may be best placed to respond to and addressing if/how that risk may be managed and any applicable legal frameworks. Whilst risks may be recognised, workers will clearly differentiate risks that are choice based and a person's right to make vs. risks which the person does not have choice or control over. This will be documented within electronic case notes, identifying when the risk has been identified and if/what actions have been taken to respond to this.

For low to moderate risks presenting during assessment of need it is proportionate for workers to make reference to this within Living Well document. This provides a clear context as to if/how risks may be mitigated and managed and within which legal framework, if any. For risks which are identified as high, whether severity or culmination of multiple low to moderate risks, completion of a positive risk assessment should be undertaken to specifically address the risks and appropriate mitigating factors in situ. The focus should be on what agencies and others involved can do to promote the person actively participating in safety planning and remaining safe in a manner they feel most comfortable with. Positive risk assessment documentation should be a tool used to support a person to visualise and meaningfully engage in risk assessment and management processes. This document can also be used when collaboratively working with other agencies to share and document the risks, steps taken to mitigate, and residual risks presented. Completed positive risk assessments will be associated to a person's electronic record.

Review of positive risk assessments and management plans should be responsive to the identified risk and any mitigating plans or actions. Workers will detail if/when risk

assessments and plans should be reviewed, if at all, to ensure this remains meaningful to the person.

Safeguarding Adults

Stage 1: Identification and Reporting of Safeguarding Concerns

***Overview**:* Stage 1 involves the identification and reporting of safeguarding concerns before the Safeguarding Adults Practitioners engage with the person at risk or experiencing abuse or neglect.

Practitioners will be mindful of S42 of the Care Act 2014, identifying where there may be a cause for concern that someone with possible care and support needs, in their area may be at risk of or experiencing harm or neglect and unable to protect themselves. This includes but is not limited to; physical abuse, emotional and psychological abuse, financial abuse, sexual abuse, coercive controlling behavior, and self-neglect.

Practitioners will have a responsibility for accurately identifying concerns, the source, type of harm, impact of harm/potential harm and urgency of the concern. Practitioners should consider and follow the Calderdale Threshold Guidance for Safeguarding Adults at Risk prior to raising a concern.

If practitioners are actively involved with a person whereby concern or information is shared, whether factually supported or not, they will make enquiries to ascertain that the person is safe and well and ascertain what action needs to be taken and what legal framework this may be under. This includes considering if this requires raising as a statutory safeguarding concern. This should be led by the person with Making Safeguarding Personal (MSP) underpinning the approach. Capacity to consent to safeguarding concerns should be considered at the point a potential safeguarding concern is identified, ensuring that the person is supported to engage with and understand what this means. In the event a person is deemed to lack capacity to consent, consideration should be given for involving a relevant representative and/or referring for an advocate. Only in circumstances where there is an immediate risk to the person and/or to the safety of another person should consent not be sought prior to raising a safeguarding concern.

Practitioners will formally report a safeguarding concern by completing the standard Calderdale Safeguarding Raising a Concern form and submitting this electronically to Gateway to Care via email. If any social care practitioner (with access to CIS) identifies the concern they will be responsible for completing respective safeguarding stage one screens on CIS.

Practitioners retain a responsibility to promoting the welfare and safeguarding children and young people (s11, Children's Act 2004) also. If information comes to the attention of a worker that a child or young person may be experiencing or at risk

of harm or neglect, they will share this information with Children's services within a timely manner. This may be by contacting Multi Agency Screening Team (MAST) or sharing information with an allocated children's worker or team.

How to Raise a Safeguarding Concern

During Office Hours

- **General Public and Professionals**: Concerns can be reported by anyone in accordance with the guidance and consideration to The Threshold Guidance for Adults at Risk in Calderdale. Reports can be made via:
    - **Safeguarding Concern Form**: Complete and submit the form to gatewaytocare@calderdale.gov.uk .
    - **Telephone**: Call Gateway to Care at 01422 393000.

- **Safeguarding Adult Team Contact Details:**
    - **Telephone (Duty):** 01422 393375
    - **Email:** safeguarding.adults@calderdale.gov.uk

- **Specific Agencies**:
    - **Police, Yorkshire Ambulance Service**: These agencies may use their own forms to notify **safeguarding concerns.** These forms are accepted as valid notifications or referrals.
    - **Calderdale & Huddersfield Foundation Trust**: Will submit concerns where the abuse or neglect occurred within a hospital setting to the Hospital Discharge Team. It is likely that the Hospital Discharge Team will give cause to the Hospital to make the safeguarding enquiries, with the Hospital Discharge Team acting as co-ordinators.

Out of Office Hours:

- **Emergency Duty Team (EDT)**: For concerns raised outside standard office hours (5:00 PM to 8:45 AM Monday to Thursday and 4:30 PM to 8:45 AM Friday to Monday), contact the EDT at 01422 288000. The EDT will assess the concern, take necessary immediate actions to address immediate and imminent risks (that cannot safely wait until the next working day), and notify Gateway to Care on the next working day.

Stage 2: Screening and Risk Assessment

Objective: To evaluate the safeguarding concern raised, apply the 'three stage statutory test' and assess the level of risk to determine whether a safeguarding enquiry is required.

The Safeguarding Adults Team is responsible for Stage 2 of the Safeguarding Adults Procedures for Learning Disabled and Neurodivergent Adults. If the three-stage test is met the Safeguarding Adult Team, will complete the stage 2 initial enquiries and if no further enquiries are required, they will complete the stage 4 closure process. If further enquiries are needed, following stage 2, the Safeguarding Practitioner will outcome stage 2 to progress to stage 3, and prepare the handover to the Learning Disability and Neurodivergent Team to undertake stage 3 and 4.

Stage 3: Safeguarding Enquiry, Safety Planning and Review

The stage 3 element of the safeguarding enquiry will be assigned to the Learning Disability & Neurodivergent Team to complete. The Safeguarding Adult Team retains responsibility for any concerns that are raised naming the alleged perpetrator of abuse as a Calderdale MBC Employee.

It maybe that the Safeguarding Adult Team or The Learning Disability & Neurodivergent Team gives cause to other agencies (for example the police, Acute and Community NHS Services), to undertake the enquiry. In these cases, the Safeguarding Adult Team or The Learning Disability & Neurodivergent Team, will co-ordinate and clearly document who is responsible for carrying out the enquiry including the timescales to complete.

Handover Process:

The Safeguarding Adult Team Manager, Team Leader or Practice Lead should review the safeguarding concern and ensure that all necessary action has been undertaken according to this Standard Operating Procedure.

The Safeguarding Adult Team Manager, Team Leader or Practice Lead contacts the Learning Disability & Neurodivergent Team Manager, Team Leader or Practice Lead explaining that they have a stage 3 prepared for handover. The Learning Disability & Neurodivergent Team Manager/Team Leader or Practice Lead should identify a practitioner within their team to take the work. A meeting should then occur between the two parties. If required and beneficial, the allocated worker within the Safeguarding Adult Team can join the meeting along with the allocated worker within the Learning Disability & Neurodivergent Team.

Undertaking a Safeguarding Enquiry

Safeguarding Practitioners (allocated workers) will formulate a safeguarding enquiry plan with the safeguarding coordinator (Team Manager, Team Leader, Practice Lead or equivalent), outlining plans and actions immediately required and timescales for completing these. Safeguarding screens will be updated regularly to ensure this captures live action, as opposed to retrospective entry. The enquiry officer must:

- *prioritise the adult's wishes, feelings, and well-being. It should focus on supporting the individual to achieve the outcomes they want, while promoting their rights to make decisions and exercise control.*

- *Ensure the person at risk is fully informed and involved throughout the enquiry process. They should be consulted about their views and desires, unless doing so would increase the risk of harm.*

The safeguarding enquiry officer will collect and evaluate relevant information from multiple sources, including the person at risk, carers, family members, and professionals involved in their care. This should include gathering evidence of abuse or neglect.

Safety Planning

Objective: To develop a safeguarding plan that addresses identified risks, outlines actions to protect and support the person at risk and ensures their safety and well-being.

Process:

- **Person-Centred Approach:** Develop the safeguarding plan in collaboration with the person at risk, ensuring their views, wishes, and desired outcomes are central to the planning process, in line with the principles of MSP. This approach emphasises the person's empowerment, choice, and control, and respects their rights and preferences.
- **Involvement of Relevant Parties:** With the person's consent, involve relevant parties such as family members, carers, and other professionals in the planning process. This collaborative approach supports a holistic understanding of the person's needs and ensures that all necessary resources are considered.
- **Action Planning and Risk Management:** Clearly outline the actions required to manage identified risks, specifying roles, responsibilities, and timeframes. The plan should be proportionate and prioritise the least restrictive options while empowering the person, as emphasised in the Care Act 2014 statutory guidance (Chapter 14 on safeguarding).
- **Compliance with Statutory and Best Practice Guidance:** Ensure compliance with the Care Act 2014, including Sections 42 (enquiry by local authority) and 44 (safeguarding adult reviews), which mandate enquiries and reviews where necessary. Refer to ADASS guidance on safeguarding roles

and responsibilities and the LGA's 'Making Safeguarding Personal Toolkit' for practical strategies to personalise safeguarding efforts and uphold high standards of care.

Documentation:

- Record the safeguarding plan in the Client Information System (CIS), including details of the person's consent, roles of involved parties, and agreed actions. Documentation should include clear objectives, timelines, and criteria for success.
- Maintain an accurate record of all communications, meetings, and decisions related to the safeguarding plan, ensuring a complete and transparent audit trail.

Review of the Safeguarding Plan (if required):

Objective:
To evaluate the effectiveness of the safeguarding plan and make necessary adjustments to ensure ongoing protection and support.

Process:

- **Scheduled Reviews:** Conduct reviews at appropriate intervals based on the level of risk and complexity of the situation. Reviews should be flexible, allowing for adjustments if significant changes occur in the person's circumstances or if new risks are identified.
- **Inclusive Review Process:** Involve the person at risk, their support network, and relevant professionals in the review process. This ensures that progress against the safeguarding plan is assessed collaboratively and that adjustments are made in response to the person's feedback and evolving needs.
- **Adjustments and Continuous Improvement:** Modify the safeguarding plan as needed based on review findings, ensuring it remains relevant and effective in addressing the person's needs and preferences. Communicate any changes clearly to all involved parties to maintain alignment and understanding.

Documentation:

- Record review outcomes in CIS, including any changes to the safeguarding plan, reasons for adjustments, and feedback from the person. Documentation should reflect ongoing risk assessments, actions taken, and the effectiveness of the plan in meeting the person's desired outcomes.

Stage 4: Closure of the Safeguarding Enquiry

Closure Process:

Objective:

- To formally close the safeguarding enquiry when identified risks have been appropriately managed and the person's safety and well-being are assured.
- This can occur following Stage 2 or Stage 3. If this element of the procedure is initiated at stage 2 then the Safeguarding Adult Team or Mental Health Team will complete this step. If the person has a stage 3 enquiry, then it is managed within the locality team.

Process:

- **Confirming Outcomes:** Confirm with the person at risk, their support network, and involved professionals that the safeguarding goals have been met and that no further actions are required. The decision to close should be based on the person's sense of safety and their feedback on the safeguarding process.
- **Ensuring Ongoing Support:** Ensure the person feels safe, supported, and informed about how to access help if new concerns arise in the future, in keeping with the MSP principle of ensuring people feel listened to and respected throughout the safeguarding process.
- **Documenting Closure:** Document the decision to close the enquiry in CIS, including the rationale for closure, the person's views, and any final actions agreed upon. Provide a comprehensive summary of the safeguarding process, actions taken, and outcomes achieved.
- **Management Oversight: The team manager or team leader will review all safeguarding enquiries and closures prior to ending the safeguarding enquiry episode.**

Documentation:

- Complete the safeguarding closure form in CIS, ensuring it captures all relevant information, including the person's feedback on their experience of the safeguarding process. Archive all related documents and correspondence in the person's case file, ensuring a thorough record of the safeguarding enquiry.
- Provide the person with a summary of the safeguarding actions taken and confirm how they can access support or re-engage with safeguarding services if necessary.

Continuous Learning and Improvement:

Objective:
To capture learning from safeguarding enquiries to improve future practice and ensure adherence to statutory and best practice standards.

Process:

- **Reflective Practice and Learning:** Use insights from safeguarding enquiries to drive continuous improvement in practice. Engage in reflective practice sessions and internal audits and incorporate learning into procedural updates and team development.
- **Guidance Adherence:** Regularly review procedures against the latest guidance from ADASS (e.g., 'Safeguarding Adults: Roles and Responsibilities') and the LGA, incorporating new recommendations and evidence-based practices. Emphasise the six principles of safeguarding (empowerment, prevention, proportionality, protection, partnership, and accountability) throughout, ensuring the focus remains on outcomes that are meaningful to the person at risk.
- **Updating Procedures:** Update safeguarding procedures based on feedback, audit findings, and evolving guidance to ensure they remain relevant, effective, and centred on the well-being of people at risk.

Continuing Health Care (CHC)

Workers will consider peoples presenting needs and if/whether these are appropriately met by the Local Authority or if these indicate a possible primary healthcare need, using the National Continuing HealthCare and Nursing Care (CHC) framework revised 2022, as a basis to inform their professional judgement. In the event that a person is eligible and or in receipt of support via an existing legal framework, such as Section 117 aftercare (discussed in following section), workers will consider which legal framework may be best placed to meet those needs and following appropriate local process for review and or application for suitable legal framework.

Workers will ensure people and/or representatives are informed of what CHC means, the process and seeking consent to complete a CHC checklist in the event healthcare needs are identified. Capacity to consent to CHC checklist and referral for a full CHC assessment will always be taken into account, ensuring that referral for advocacy or a representative is involved to appropriately support the person where their mental capacity is lacking.

Section 117 After-Care

What is Section 117 After-Care?

Section 117 of the Mental Health Act 1983 (as amended, 2007) places a joint duty on local authorities and Integrated Care Boards (ICB) commissioners to provide after-care services for people that have previously been detained under treatment sections of the Mental Health Act, i.e.

- section 3 (admission for treatment)
- section 37 ('hospital order') – includes s.37/41
- section 45A (where a criminal court imposes a prison sentence but directs they start their sentence in a psychiatric hospital for treatment)
- sections 47 and 48 (the transfer of prisoners to hospital)

The duty to provide after-care services begins at the point that someone leaves hospital and lasts for as long as the person requires the services.

Section 117 does not apply to those detained under:

- Section 2
- Section 4
- Section 5 (2) or (4)
- Informal patients

Section 117(6) defines 'after-care services' as: '…services which have both of the following purposes:

a) meeting a need arising from or related to the person's mental disorder; and

b) reducing the risk of a deterioration of the person's mental condition (and accordingly, reducing the risk of the person requiring admission to a hospital again for treatment for mental disorder).'

The 'ultimate aim' of s117 after-care services is to maintain people in the community (MENTAL Health Act Code of Practice para 33.3)

The Mental Health Code of Practice states that although the duty to provide after-care services start as soon as the patient is admitted to hospital, local authorities and the ICB should take reasonable steps, in consultation with the care co-ordinator and other members of the multi-disciplinary team to identify appropriate after-care services for patients in good time for their eventual discharge from hospital or prison (CoP 33.10)

No Recourse to Public Funds

Section 117 after-care services are available regardless of a person's immigration status or their nationality. Immigration exclusions under Schedule 3 Nationality, Immigration and Asylum Act 2002 do not apply. When preparing to discharge someone from hospital who has no recourse to public funds from Section 117, due regard must be given to the person's immigration status and entitlement to support in the UK.

The need for provision to meet common and care and support needs not related to a mental disorder must be assessed separately under the Care Act 2004 and Human Rights Act 1998

What are After-care Services?
After-care services can be a range of services that meet the needs of the persons mental disorder and reduce the risk of their mental health deteriorating e.g.

- Residential care
- Supported living.
- Medication
- Outpatients' clinic
- Assistance with personal care and daily living tasks
- Support for emotional needs.
- Support claiming benefits, looking for job, gaining an education or voluntary work.
- Anything more specialist to keep the persons mental health stable.

Prior to discharge from a mental health hospital a person entitled to Section 117 after-care services must have a Section 117 after-care discharge planning meeting to ensure that a Section 117 after-care assessment (or review where appropriate) has been jointly completed by the Mental Health Social Care Team and the ICB.

Inpatient Ward Contact Mental Health Social Care Team and ICB
Once the inpatient ward is aware that a patient has Section 117 entitlement, they will contact the Mental Health Social Care Team via the team's central referral email inbox. For those persons already known and allocated to the team the Team Manager or the Referral Information Coordinator will directly refer the request for a Section 117 after-care assessment (or review where appropriate) to the allocated worker. Where the person is not to the team the Team Manager, or the Referral Information Coordinator will allocate a worker to complete the assessment (or review).

Contacting the ICB
The worker should make contact with the ICB as where possible the assessment should be completed in partnership with the ICB as the local authority cannot fund health services, and the focus of the Mental Health Social Care Team will be on the persons social care needs, where as the ICB will focus on the persons ongoing health needs. The conversation with the ICB must be recorded in the persons case note in CIS. A date and time that is convenient to both workers should be agreed to visit the person in hospital and undertake the assessment.

Section 117 After-Care Assessment Process
The after-care assessment should be a collaborative process, involving the person, their family or carers, and a multidisciplinary team of professionals, including social workers, mental health nurses, psychiatrists, and other relevant professionals. The aim is to create a holistic and sustainable plan that supports the persons recovery and integration into the community. The assessment should be comprehensive, person-centred, and should cover the following key areas:

Assessment of Needs

- **Mental Health Needs:** Assess the person's current mental health condition, including any ongoing symptoms or issues that need management.
- **Physical Health Needs:** Evaluate physical health conditions, which may require ongoing care or affect mental health.
- **Social Care Needs:** Identify any social care requirements, such as assistance with daily living activities, personal care, or accommodation needs.
- **Medication Management:** Review medication needs, including the prescription, administration, and any potential side effects or monitoring requirements.

Assessment of Risks

- **Risk to Self or Others:** Assess any potential risks the person may pose to themselves or others, including the risk of self-harm or suicide.
- **Vulnerability:** Consider any factors that make the person vulnerable, such as isolation, financial difficulties, or lack of support networks.
- **Safeguarding Issues:** Identify any safeguarding concerns, particularly if the person is at risk of abuse or neglect.

Support Network and Involvement of Carers

- **Family and Carer Involvement**: Involve family members or carers in the assessment process, ensuring their views are considered, and assess their ability and willingness to provide support.
- **Community Support:** Evaluate the availability and adequacy of community support, including peer support groups and voluntary sector services.

Accommodation Needs

- **Current Housing Situation:** Assess the suitability of the current living arrangements, and whether they support the person's mental health recovery.
- **Need for Supported Accommodation:** Determine if supported housing or other specialised accommodation is required.

Employment, Education, and Meaningful Activity

- **Employment or Education:** Discuss opportunities for the person to engage in employment, education, or vocational training as part of their recovery process.
- **Meaningful Activities:** Explore hobbies, social activities, and other meaningful engagements that can contribute to the person’s well-being.

Financial Assessment

- **Welfare Benefits:** Review the person's financial situation, ensuring they are receiving any welfare benefits to which they are entitled.

- **Financial Support Needs:** Identify any additional financial support needs, such as budgeting assistance or debt management.

Plan for Crisis or Relapse

- **Crisis Plan:** Develop a clear plan for managing any future mental health crises, including who to contact and what steps to take.

- **Relapse Prevention:** Establish strategies for preventing relapse, including regular check-ins with mental health professionals and early warning signs to monitor.

Legal and Advocacy Needs

- **Advocacy Services:** Ensure the person is informed about their rights and has access to advocacy services if needed.

- **Legal Considerations:** Address any legal issues, such as ongoing court cases, or involvement with the criminal justice system.

Review of Previous Care and Outcomes

- **Effectiveness of Previous Care:** Review the effectiveness of the care received during the period of detention and how this has impacted the person's recovery.

- **Learning from Previous Experiences:** Use insights from previous care and support to inform the current after-care plan.

Development of a Comprehensive After-care Plan

- **Personalised and Strengths-Based After-care Plan:** Develop a detailed and personalised after-care plan that outlines all the services and support the person will receive.

- **Coordination of Care:** Ensure that all services are coordinated, with clear roles and responsibilities for each professional involved in the person's care.

- **Regular Reviews:** Set up a schedule for regular reviews of the after-care plan to ensure it continues to meet the person's needs and to make any necessary adjustments.

Documentation and Communication

- **Documenting the Assessment:** Thoroughly document all aspects of the assessment and the resulting after-care plan in the Section 117 Assessment Template

- **Sharing Information:** Ensure that relevant information is shared with all professionals involved in the person's care, while respecting confidentiality.

Cultural, Religious, and Language Needs

- **Cultural Sensitivity:** Consider the person's cultural and religious background when planning after-care services.

- **Language Needs:** Provide interpretation or translation services if necessary to ensure the person fully understands the assessment and care plan.

Consent and Capacity

- **Assessing Capacity:** Evaluate the person's capacity to make decisions about their care, following the principles of the Mental Capacity Act.

- **Obtaining Consent:** Ensure that the person consents to the after-care plan, or that decisions are made in their best interests if they lack capacity.

Care Act or Continuing Health Care Assessment

- Consider what needs don't fall within Section 117 and may fall within the scope of the Care Act or Continuing Health Care, e.g., physical disabilities.
- Arrange these assessments where appropriate

Speaking to Relevant Professionals, Carers, Representatives, Family and or Friends

During the assessment the Mental Health Social Care Team worker must consider if the following people will need to be contacted as part of the assessment process:

- Responsible Clinician
- Nurses and other professionals involved in caring for patient in hospital.
- Psychologist, Community Psychiatric Nurse, Care Coordinator and members of community mental health team
- Patients GP is especially important if the patient is subject to a Community Treatment Order
- Any carer who will be involved in looking after patient outside the hospital (including cases of children/young people those with parental responsibility)
- Patients' nearest relative (within the meaning of the Mental Health Act, Section 23)
- A representative from any relevant voluntary and or community organisation
- In the case of restricted patients, the MAPPA Coordinator
- In the case of transferred prisoners, probation service
- Representative of housing authority if accommodation is an issue
- Employment experts, if employment is an issue
- ICB representative (if they cannot be part of the assessment)
- Independent Mental Health Advocate or Independent Mental Capacity Advocate (if the patient has one)
- Any other representative nominated by a patient
- Anyone with authority under the Mental Capacity Act to act on a patient's behalf.

Points to Consider

- **Continuing Health Care:** Where a person is eligible for Section 117 services, these must be provided under s117, not CHC. **BUT:** might also be eligible for CHC in respect of specialist health needs which have no connection to mental health at all, e.g., motor neurone disease, muscular dystrophy, etc.

- **Legislative Framework:** It is essential to be clear about the legislative framework under which someone is being assessed and the legal basis of why services are being provided. The Care Act eligibility criteria and 10 Care Act Outcomes are different tests to those applied under the MH Act s117 Aftercare criteria.

  We need to consider whether all required care can be provided within the s117 criteria. Are there needs not related to mental health (i.e., physical care needs) that might fall within NHS Continuing Health Care or the Care Act?

- **Accommodation:** Provision of accommodation will fall under Section 117 if the accommodation has support features to address mental health needs, e.g., residential care with special features, 24-hour on-site staffing, CCTV, organised activities, and welfare checks, monitoring of a person's mental state and reducing the risk of mental health deterioration, etc.

  Needing somewhere to live ('bare' accommodation, i.e., a mere roof over one's head) is unlikely to fall within s117 (R (Mwanza) v L.B. Greenwich, 2010, R (Afework) v LB Camden 2013 (both pre–Care Act)). However, accommodation might need to form part of the Section 117 after-care package if other necessary services would be 'effectively useless' without it, e.g., if a person has no settled home etc. see R (SG) v L. B. Haringey (2017), a Care Act case concerning someone with mental health problems.

- **Section 117 Funding:** Any commissioned support eligible to be funded under Section 117 after-care is subject to local policy agreement regarding funding division and respective processes for budget agreement from Local Authority and/or ICB.

  People in receipt of commissioned support funded under Section 117 after-care are subject to annual reviews both singularly and jointly with the ICB as per existing pathway.

Unpaid Carers

As part of our prevention and early help duty all team members will ensure that they share information to colleagues and partner agencies regarding carers individual rights to access an assessment and support in their own right. This will include verbally sharing information with regards to carer support services, sharing of commissioned carers support and providing information and advice in written format. The team recognise that some agencies may encounter informal caregivers / carers

prior to them contacting adult services, as such sharing of information may enable them to access help and support in their own right at an earlier point.

For those people whom the team are actively working with, consideration will always be given to unpaid carers involvement and ensuring they are given information and advice on carers assessments, carers support and carer specific resources. Offers will be made for a carer for a social worker to support them in completing a carers assessment, providing this for them to complete and return in their own time or to refer them to carers resource to support to complete. Where it is established, the carer has needs the worker may be allocated for the purposes of carers assessment on the electronic recording system and consideration will be given to applying for a carers budget. Carers personal budget pathway is supported and universal for all adult care services.

The worker will be responsible for submitting a carers personal budget application to the Management Team, outlining the amount and use of the budget. This will be reviewed and if agreed, escalated to nominated carers lead for setting up the carers budget. Documentation will be associated to the carers electronic record.

This will be reviewed on a yearly basis by the carers lead, taking into account the efficacy and need for the budget and whether it should remain for a further 12-month period.

For unpaid carers who may not wish to access carers support / assessment / via social care, this will be clearly documented within the cared for persons electronic record so that any future contact there is transparency about the type and support offered and which should be reviewed.

Young Persons Transitions

A transitional pathway is currently in development specifically for children and young people transitioning to adult services whereby they have a learning disability and/or neurodiverse diagnosis.

Presently the operational process is as follows:

- Adult services have representation at the Children and Young Peoples external placements panel and in the Children Looked After - Adults Transitions Meeting. These provide the opportunity to identify, and track referrals to Adult Services for, particularly complex Children Looked After who may require Adults Social Care.
  This provides early opportunity to discuss and identify young people with complex needs who may be likely to require transition through to adult services in future, specifically the Learning Disability and Neurodivergent social work team. Such referrals should be discussed, agreed as suitable by either the Operations Manager or Service Manager and sent to Gateway to Care on a general referral form. Once the referral is received on the electronic recording system it is added to the electronic spreadsheet to use in compliment of the electronic recording system referral lists. The spreadsheet

is date ascending for referral submission and color coded for priority rating. Referrals should preferably be raised prior to the young person turning 17 but not before the 16th birthday, to ensure that adult social care intervention is probable to be required and to facilitate time for allocation and relationship building.

- Children and young people's services workers will complete a general referral form and submit via Gateway to Care. Once the referral is received on the electronic recording system the Team Manager will set up a meeting to discuss the young person's needs, applicable adult legislation and interventions which could be offered and agreeing an appropriate pathway forward. This may include but is not limited to; no role for adult social care involvement and referral to be closed, provision of information and advice, referral to be subjected to process outlined in staying safe and well for assessment process.

- Parents/carers of the young person will complete a general referral through Gateway to Care, providing all information required for decisions to be made around correct team of support, for signposting information to be provided and so that decisions can be made around priority.

- Educational services, mainly SEN schools within the borough and also the SEN services within the LA will make referrals direct to Gateway to Care whereby the referral is entered onto the electronic recording system. ECHP review meetings for young people in year 14 are attended to ensure that plans are made for post formal education support to be considered where deemed necessary.

Referrals that proceed to allocation will involve workers liaising closely with children and young people's staff, Pathways Service, SEN team and possible ICB, ensuring there is transparency regarding lead agency, legal responsibility, and a clear pathway in regarding to actions, timescales and accountability by each respective person. Adults' worker will ensure they proactively in-reach any partner agencies that may be likely to require involvement once adulthood is reached. This can include convening and holding multi-agency meetings to promote an effective transition place.

In preparation for the 18th birthday approaching of the young person, there should be sufficient information and evidence to support the adult's worker identifying eligible needs within the applicable legal framework (consideration to Section 117 aftercare and/or CHC framework) and following established process for agreeing budgets to commission any required support. The focus will be on ensuring the young person continues to receive the right support, at the right time from the right agency.

Mental Capacity Act Assessments

Decision Making, Consent, and Mental Capacity (opens as a PDF).